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### Weighing Medical Judgments: Explaining Evidentiary Preferences for Treating Physician Opinions in ERISA Cases after Black & Decker Disability Plan v. Nord

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WEIGHING MEDICAL JUDGMENTS: EXPLAINING  
 EVIDENTIARY PREFERENCES FOR TREATING PHYSICIAN  
 OPINIONS IN ERISA CASES AFTER *BLACK & DECKER*  
*DISABILITY PLAN V. NORD*

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INTRODUCTION

The proper weight to be given the medical opinion of a disability claimant’s treating physician has presented a significant point of contention in various legal settings. The subject bristles with complexity as it bisects evidentiary and broader social policy concerns.

Historically, American courts have not favored the application of rules of weight in the evaluation of evidence,<sup>3</sup> on the view that they are antithetical to

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the role of the jury.<sup>4</sup> This bias against rules of weight reveals itself in modern evidence law as well in the “all-or-nothing” character of evidence rules.<sup>5</sup> From this perspective, questions of admissibility present issues for a judge to decide; the task of evaluating evidence goes to the jury.<sup>6</sup>

By contrast, rules of weight work to “structure a comparable hierarchy of evidentiary sources.”<sup>7</sup> As such, they are rightly understood as intruding on the discretion of the fact finder,<sup>8</sup> in that they grade the reliability of specific types of evidence. Examples of arguments for or application of a treating physician rule are frequently found in the administrative law setting, which has proven more receptive to rules of weight.<sup>9</sup>

One of the more significant examples is the rule favoring the testimony of treating physicians in Social Security disability cases.<sup>10</sup> By regulation,<sup>11</sup> the Social Security Administration regards treating physicians’ opinions as providing a “detailed, longitudinal picture” of impairment inaccessible from other sources, such as objective medical findings standing alone.

Even in the administrative law setting, however, rules of weight have not found unequivocal acceptance.<sup>12</sup> Significantly, though often resorting to administrative law analogies in Employee Retirement Income Security Act (ERISA) cases, the Supreme Court in *Black & Decker Disability Plan v. Nord* rejected the treating physician rule in judicial review of disability claim denials under ERISA.<sup>13</sup> As will be addressed in the discussion of that holding, *infra*, the Supreme Court’s rejection of the treating physician rule in ERISA cases does not imply that district courts must disregard the superior probative value of treating physicians’ opinions when appropriate.

The article will develop this premise through analysis of a series of federal district court decisions that have credited the assessments of treating physi-

3. TERENCE ANDERSON, DAVID SCHUM & WILLIAM TWINING, ANALYSIS OF EVIDENCE 226 et. seq. (Cambridge Univ. Press 2d ed. 2005) (1991).

4. Charles L. Barzun, *Rules of Weight*, 83 NOTRE DAME L. REV. 1957, 1959–60 (2008).

5. According to Barzun, “[m]odern evidence law tends to be an all-or-nothing affair. Most rules of evidence are admissibility rules that tell judges simply whether or not a given piece of evidence may be viewed by the factfinder.” *Id.* at 1958.

6. *Id.*

7. *Id.* at 1959.

8. For example, substantive rules of law (where outcomes are determined “as a matter of law”), legal presumptions (where inferences are encouraged from circumstantial evidence), rules of corroboration (requiring corroboration of certain forms of testimony) and judicial comment (permitting judges to give their opinion to the jury about evidence), all can be viewed as impinging on the province of the jury.

9. *Id.* at 1960-61, 1975–76.

10. In disability benefit cases, regulations require that the administrative law judge accord more weight to the testimony of the treating physician than to that of other experts in adjudicating a disability benefits claim. See 20 C.F.R. § 404.1527(d)(2) (2007).

11. *Id.*

12. See *Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 370 (1998).

13. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830-31 (2003).

cians over those of other reviewing physicians. Distinguishing *Nord*, these courts have accorded more relative value to treating physician opinions in cases where psychiatric or mental conditions are in issue.

This article argues that these decisions can be reconciled with *Nord*. At the same time, this article submits that a frequently proffered rationale for doing so raises analytical problems. A distinction described in terms of objective versus subjective clinical diagnoses fails to provide a sufficient warrant for crediting the opinions of treating physicians over reviewing physicians.<sup>14</sup>

A more defensible explanation can be offered based upon the superior forensic vantage point of examining physicians in certain contexts. When viewed from this perspective, the probative force of an opinion by an examining physician may be justifiably preferred over a reviewing physician when assessment of symptoms requires personal observation. A further advantage of this analysis lies in its potential extension beyond psychiatric conditions when warranted, for example, as in instances of co-morbidity. In the end, what is known as the treating physician rule has become de facto an “examining physician” preference, or factor.

Further, since *Nord*, the Supreme Court has decided *Metropolitan Life Insurance Co. v. Glenn*,<sup>15</sup> in which it held the payment of benefits by an entity that both pays and decides claims created a conflict of interest. In such cases, the evaluative tool suggested here can help the court in its determination that assessment of disability was not biased, arbitrary, or capricious.

### I. THE TREATING PHYSICIAN RULE AS A RULE OF WEIGHT

The “weight” assigned to a datum of evidence may be defined as the probative force of an evidentiary fact. It is a contingent variable that varies in significance and in proportion to its tendency to prove the proposition for which it is offered.<sup>16</sup>

When formulated as a rule, however, weight is fixed to a class of evidence as a form of guidance for the fact finder. A rule of weight grades a class of evidence by indicating the extent to which the evidence (if credible) will result in a correct finding on the factual issue to which the evidence speaks.<sup>17</sup>

Rules of weight, like other evidentiary rules, such as those governing admissibility of evidence and presumptions, serve to channel the permissible

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14. In fact, the objective-subjective distinction, *infra* section III.A., can be criticized as a rule of weight that serves as proxy for the now-discredited treating physician rule.

15. *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343, 2348 (2008).

16. Relevance, credibility, and weight have been described as three essential characteristics of an evidential datum necessary to evaluate the relationship between the evidence and a hypothesis. An assessment of the probative force or “weight” of evidence may serve as a sort of natural language abbreviation for the probabilistic connection between a factual premise and an inference from that premise. ANDERSON, SCHUM & TWINING, *supra* note 2, at 229.

17. Barzun, *supra* note 3, at 1985, 1992.

inferences of the fact finder. In each case, the justification for the evidentiary rules lies in presumed warrants of reliability based upon general experience in drawing factual inferences. Unlike rules of admissibility, however, rules of weight exhibit a nuanced aspect wherein the fact finder examines the evidence in question but with what is effectively a comment on its relative worth.<sup>18</sup>

The treating physician rule may be described as a rule of weight in that it holds the opinions of treating physicians of superior probative force to those of non-treating physicians. For historical reasons, Anglo-American evidence law does not offer many examples of rules of weight.<sup>19</sup> Moreover, the notion of the treating physician rule as a rule of weight implies a rigid formalism that can be misleading.

#### A. Rules of Weight in the Rationalist Tradition of Evidence

The rules comprising the law of evidence presuppose a number of philosophical positions that have collectively been described as part of a "rationalist tradition."<sup>20</sup> The rationalist tradition implies moral realism in its goal of obtaining truth through rational means. It comprehends the purpose of evidence and civil procedure as aiding the discovery of objective facts so that substantive law may be correctly applied, and this in service of the paramount goal of "the rectitude of decision."<sup>21</sup>

The historical development of this perspective requires an appreciation of the rationalistic orientation of the Enlightenment period in which it arose.<sup>22</sup> The underlying presumption of the rational competence of the individual led to a natural prejudice against rules of evidence that would exclude evidence (or weigh its probative force).<sup>23</sup> First articulated in Jeremy Bentham's philosophical work in eighteenth century England,<sup>24</sup> this view found robust expression in American jurisprudence in the person of John Wigmore. In his treatise, Wigmore states:

When evidential data are once admitted by the judge and there is a sufficiency of them to entitle the case to go to the jury, their individual and total weight or probative value is for the decision of the jury. This signifies, first, that there are no rules of law to bind them on the

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18. *See id.* at 1959.

19. *See* ANDERSON, *supra* note 3.

20. WILLIAM TWINING, THEORIES OF EVIDENCE: BENTHAM AND WIGMORE at 14 (Widenfeld & Nicolson 1985).

21. Barzun, *supra* note 3, at 1966.

22. TWINING, *supra* note 20, at 1-4.

23. Barzun, *supra* note 3, at 1959.

24. *See, e.g.*, 1 JEREMY BENTHAM, RATIONALE OF JUDICIAL EVIDENCE (Fred B. Rothman & Co. 1995) (1827).

subject..., and, second, that the judge's own view of the weight of the evidence is not to control the jury.<sup>25</sup>

Rules of admissibility became the central concern of the law of evidence with questions of weight left to the province of the trier of fact.<sup>26</sup>

## B. The Treating Physician Rule in the Agency Setting

In view of the foregoing, the view that treating physicians' opinions are given special weight in some adjudicatory settings might seem anomalous. This is especially so in light of a marked trend away from deference to professional standards over the past so many decades.

In administrative law proceedings, however, the concerns for the province of the jury in the rationalist tradition have no place. In fact, the growth of the administrative state and, concomitantly, the popularity of alternative dispute resolution, have witnessed incursions into the domain of judges and jurors alike.<sup>27</sup>

Furthermore, recent scholarship has noted a shift in concern for the "rectitude of decision" in favor of greater concern for finality and efficiency.<sup>28</sup> Rules of weight offer advantages in expedient assimilation of evidence (and some would argue greater accuracy).<sup>29</sup>

While the foregoing observations may serve to explain how rules of weight have found greater acceptance in the agency setting, the treating physician rule has not been consistently applied.<sup>30</sup> In fact, when the rule has been applied, its intended use may have been as a means of introducing judicial discretion in cases where judicial review was otherwise sharply circumscribed by a deferential standard of review.<sup>31</sup>

The uneven application of rules preferring the opinions of treating physicians may be understood as a consequence of a devalued view of professional opinion. The treating physician rule derives from a line of cases, traced back to at least 1977, that assigned a "substantially greater weight" to the opinion of the treating physician in matters of impairment.<sup>32</sup> The historic defe-

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25. 9 WIGMORE ON EVIDENCE § 2551 (Little Brown and Company 1981). Wigmore goes on to caution that this does "not signify that the judge may not *comment* upon the general weight of the evidence, or of particular parts of it, to assist the jury in reaching their conclusion." *Id.*

26. Barzun, *supra* note 3, at 1958.

27. *See id.* at 1977.

28. ANDERSON, SCHUM & TWINING, *supra* note 2, at 84.

29. Barzun, *supra* note 3, at 1986.

30. *Nord*, 538 U.S. at 830 n.3.

31. *See Rachel Schneider, A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391(1996)

32. *Id.* at 376; *see also* *Allen v. Weinberger*, 552 F.2d 781, 785-76 (7th Cir. 1977). Prior to *Allen*, a line of cases state much the same argument for deference to treating physicians. *See Mefford v. Gardner*, 383 F.2d 748, 761 (6th Cir. 1967); *Selig v. Richardson*, 379 F. Supp. 594, 601-02 (E.D.N.Y. 1974); *Tritt v. Richardson*, 320 F. Supp. 871, 873 (W.D. Va. 1970).

rence of the courts to medical opinion has been put down to a variety of factors, including:

(1)[A]lack of understanding of the knowledge and practice of medicine, which creates a judicial fear of destroying the physician-patient relationship; (2) a belief shared with society at large that physicians know what is best for their patients; (3) a belief that physicians already tell patients all that patients need to know and (4) [a] reluctance to interfere with the application of an esoteric body of knowledge.<sup>33</sup>

The differentiation between “professions” and “trades” is another reason for judicial deference to medical opinions. This distinction stems from a common regard for the professions and for their special cache of knowledge. According to social historian Paul Starr, “expertise alone was [historically] insufficient [to obtain the status of “profession”] unless accompanied by a ‘service rather than profit orientation.’ Only then could the occupation obtain the social and legal privileges associated with the professions. This fidelity to the customer distinguish[ed] a profession from a trade.”<sup>34</sup> Commensurate with the respect afforded “professions” were the customs to which they subscribed. As a consequence, the special knowledge of what was “best” practice in a particular profession was given a somewhat wider berth in the tort context, but none greater than in the case of the medical profession. There, “reasonableness” was set not objectively, but by custom.<sup>35</sup>

However, as Phillip G. Peters has written,

[J]udicial deference to physician customs is eroding. Gradually, quietly and relentlessly, state courts are withdrawing this legal privilege.... The slow but steady judicial abandonment of deference to medical custom began in earnest in the 1970s, continued in the 1980s and retained its vitality through the 1990s. Showing no signs of exhaustion, this movement could eventually become the majority position. Furthermore, many of the states that theoretically continue to defer to custom actually apply the accustom-based standard of care in a way that operates very much like a reasonable physician standard.<sup>36</sup>

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33. Gerald F. Tietz, *Informed Consent in the Prescription Drug Context: The Special Case*, 61 WASH. L. REV. 367, 376 (1986). Tietz’s article sets out a general history of the deference, and notes that the courts are reluctant to “impose legal standards that [might] pose unique and difficult questions regarding medical practice.” *Id.*

34. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 81–92 (1982).

35. See PROSSER AND KEETON ON TORTS § 32, at 189 (W. Page Keeton et al. eds., 5th ed. 1984) (“the medical profession ... [is given] the privilege ... emphatically denied to other groups, of setting their own legal standards of conduct, merely by adopting their own practices). Arguably, the treatment of medical custom as evidence worthy of more weight than evidence of what is the “best practice” in the field is another rule of weight, albeit one that the courts have been displacing in favor of a reasonable physician standard.

36. Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 164 (2000).

Peters' article explains the unusual subsidiary doctrines<sup>37</sup> that the customary medical practice rule spawned, and states that twelve states, as of the turn of the millennium, had rejected the deference to medical custom standard,<sup>38</sup> or had taken steps toward had taken steps towards phrasing the standard in terms of the "reasonable physician."<sup>39</sup>

Notable in the *Nord* decision is a candid (if not cynical) assessment of treating physicians' opinions consistent with this cultural trend. The Court explains its rejection of a rule of weight on the view that, just as physicians employed by managed care entities may have "incentives" to make a finding of "not disabled," so a treating physician may have an incentive to find the opposite. This questioning of physician motives reveals a business oriented assessment of professional opinion quite at odds with the historical view.

The following section will set forth the rationale behind the Supreme Court's rejection of the treating physician rule in ERISA disability cases. In this analysis, the objective will be to discern what preference, if any, treating physicians' opinions have under the holding in *Nord*. Following that discussion, the argument that psychiatric and mental diseases are an instance of such a preference will be reviewed with particular attention to the objective-subjective principle enunciated in those cases.

## II. REJECTION OF THE TREATING PHYSICIAN RULE IN ERISA CLAIMS ADJUDICATION

As noted above, the Supreme Court in *Nord* rejected the treating physician rule in the context of private disability plans. A brief overview of the rationale of that ruling will provide the background necessary to analyze cases distinguishing this opinion.

Black & Decker sponsored an ERISA-governed employee welfare benefit plan that provided benefits for eligible employees suffering from a disability. Although Black & Decker funded claims and served as the plan administrator, it engaged Metropolitan Life Insurance Company (MetLife) to render initial recommendations on benefit claims. Under the terms of the plan, disa-

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37. *Id.* at 166-67. These doctrines include the requirement of medical testimony to educate the jury on customs in the field; a preclusion of liability when there is more than one school of thought as to best practice; the importance of local norms of practice; an insulation of reasonable treatments that have bad results; the requirement that physicians with unique information "use it regardless of customary norms"; allowing patient consent to non-customary treatments when customary treatments fail; allowing patients to opt-out of conventional treatments; allowing plaintiffs' verdicts "despite the absence of expert testimony and despite evidence that the physician complies with customary practice when there is a matter of "common knowledge"; and "endless refinements of the phrasing of the standard of care." *Id.*

38. *Id.* at 172.

39. *Id.* at 180; see also Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639 (1992) (criticizing professional judgment deference in committing procedures and expansion of use of that deference on the whole).



bility determinations were to be made by the plan administrator “‘based on suitable medical evidence and a review of the Participant’s employment history that the [plan administrator] deems satisfactory in its sole and absolute discretion.’”<sup>40</sup> Disability was defined as “‘the complete inability . . . of a Participant to engage in his regular occupation with the Employer.’”<sup>41</sup>

Nord, a participant in the plan, applied for disability. MetLife denied Nord’s application, whereupon Nord proceeded through several levels of further consideration and appeal. The issue eventually developed into a dispute based upon a difference of medical opinion.

Nord’s treating physicians concluded that he suffered from a degenerative disc disease and chronic pain that rendered him unable to work. MetLife referred Nord to a neurologist for an independent examination, however, and that physician reached a different conclusion. Though the claims administrator’s neurologist agreed that Nord suffered from a degenerative disc disease and chronic pain, he concluded that, aided by pain medication, Nord could perform sedentary work. MetLife recommended that Nord’s claim be denied and Black & Decker accepted this recommendation.

Nord ultimately filed suit against the plan, wherein he challenged the benefit denial in a claim for benefits under 29 U.S.C. 1132(a)(1)(B). The district court applied an abuse of discretion standard of review based upon a grant of authority in the plan document.<sup>42</sup> On cross motions for summary judgment, the district court ruled for the plan. On appeal to the Ninth Circuit, Nord challenged the district court’s decision allowing the plan to accept the reviewing physician’s opinion over that of his treating physicians.

The case arrived at the Ninth Circuit at a time when the federal courts were struggling with the significance of benefit administrators that operated under a conflict of interest.<sup>43</sup> This historical setting adds an additional layer of complexity for those seeking to apprehend what the Ninth Circuit intended by its invocation of the treating physician rule.

In *Regula v. Delta Family-Care Disability Survivorship Plan*,<sup>44</sup> the Ninth Circuit had previously required greater scrutiny of decisions by administrators that both funded and paid claims. If an apparent conflict of interest could be shown to have affected the administrator’s decision, review would be *de novo* rather than for an abuse of discretion.

At this point, the standard of review decision intersected with the treating physician rule’s applicability. Under *Regula*, rejection of the opinions of

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40. *Nord*, 538 at 826 (quoting *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 826 n.1 (9th Cir. 2002)) (alteration in original).

41. *Id.* at 825–26 (quoting *Nord*, 296 F.3d at 826 n.2).

42. *See Nord*, 296 F.3d at 828 (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)).

43. The Supreme Court had previously observed that conflicts of interest constituted a factor to be considered upon judicial review of benefit denials. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).

44. 266 F.3d 1130, 1147 (9th Cir. 2001).

the beneficiary's treating physicians could establish conflict where the rejection was not "sufficiently supported by the record."

Following its holding in *Regula*, the Ninth Circuit in *Nord* approached the dispute in medical opinion with a keen eye to the potential conflict of interest of the plan administrator. The Court observed that:

Thus, the long-term treating physicians and Black & Decker's independent (but one-time) clinical examiner disagreed. The same clinical materials were available to both. In such a circumstance, under the treating physician rule, the plan administrator can reject the conclusions of the treating physicians only if the administrator "gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record."<sup>45</sup>

Under this test for bias, the plan administrator's neglect of the treating physicians' opinions both altered the standard of review to de novo and resolved the ultimate issue inasmuch as the only evidence opposing Nord's claim was the sole opinion of the reviewing physician.

The only evidence advanced by Black & Decker to dispute the evidence of Nord's disability is Dr. Mitri's opinion that Nord is capable of performing sedentary work. A scintilla of evidence or evidence that is not significantly probative does not present a genuine issue of material fact. . . . We conclude that the lone opinion of Dr. Mitri, the doctor hired by Black & Decker, could not reasonably overcome all the other evidence demonstrating that Nord is disabled. Dr. Mitri's opinion is overwhelmed by substantial evidence in the record, including the opinions of three treating physicians that Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner.<sup>46</sup>

Thus, the Ninth Circuit's incorporation of the treating physician rule into the ERISA claims adjudication process arose as an element in ascertaining the proper standard of review. The decision held particular significance as it stood in opposition to that of other circuit courts of appeal. For example, the Fourth Circuit had declined to adopt the treating physician rule as applied in Social Security disability cases in an ERISA claim for benefits case, *Elliott v. Sara Lee Corp.*<sup>47</sup>

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45. *Nord*, 296 F.3d at 831 (quoting *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999) (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995))).

46. *Id.* at 832 (citations omitted)

47. 190 F.3d 601, 606 (4th Cir. 1999). The Seventh Circuit recounted the varying opinions on the issue in *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003), stating:

The courts are divided on whether the presumption applies to benefits determinations by administrators of ERISA plans. Compare *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 831 (9th Cir. 2002), *cert. granted*, 123 S. Ct. 817 (2003); *Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 532-33 (6th Cir. 2003); *Jackson v. Metropolitan Life Ins. Co.*, 303 F.3d 884, 888 (8th Cir. 2002); *Skretvedt v. E.I. Du Pont de Nemours & Co.*, 268 F.3d 167, 184 (3d Cir. 2001), and *Regula v. Delta Family-Care Disability Sur-*

This variance in opinions gave rise to a Supreme Court grant of certiorari to resolve the conflict in the circuits. Reversing the Ninth Circuit, the Court held that plan administrators are not obliged to accord special deference to the opinions of treating physicians. Though ERISA and the Secretary of Labor's regulations under the Act require "full and fair" assessment of claims,<sup>48</sup> the Court held that this mandate did not require plan administrators to credit the opinions of treating physicians over other evidence relevant to the claimant's medical condition.

In rejecting the treating physician rule, the Court stated:

As compared to consultants retained by a plan, it may be true that treating physicians, as a rule, "have a greater opportunity to know and observe the patient as an individual." . . . [T]he assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks.<sup>49</sup>

*Nord* thus established that, unlike Social Security disability proceedings,<sup>50</sup> ERISA claims adjudicators need give no special weight to treating physician opinions. Plan administrators "may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician."<sup>51</sup> On the other hand, courts may not require administrators to accord special weight to the opinions of a claimant's physician or require explanation when they prefer reliable evidence over a treating physician's evaluation.<sup>52</sup>

### III. DISTINGUISHING *NORD* IN THE CONTEXT OF PSYCHIATRIC EVALUATIONS

The Supreme Court rejected the application of the treating physician rule to ERISA claims adjudications for reasons largely unrelated to accuracy of the

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ivorship Plan, 266 F.3d 1130, 1139 (9th Cir. 2001), with *Connors v. Connecticut General Life Ins. Co.*, 272 F.3d 127, 135 n. 4 (2d Cir. 2001); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999), and *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992).

48. See 29 U.S.C. § 1133 (2006); 29 C.F.R. § 2560.503-1 (2002).

49. *Nord*, 538 U.S. at 1251.

50. The Court distinguished the purpose of Social Security proceedings from that of private disability plans: "By accepting and codifying a treating physician rule, the Commissioner sought to serve that need. Along with other regulations, the treating physician rule works to foster uniformity and regularity in Social Security benefits determinations made in the first instance by a corps of administrative law judges . . . In contrast to the obligatory, nationwide Social Security program, "[n]othing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Nord*, 538, at 833.

51. *Id.* at 834.

52. *Id.*

claims decision. On the whole, the Court based its conclusions on broad rules of statutory interpretation and agency deference.

For example, the court observed that:

1. ERISA does not provide that plan administrators must show special deference to the opinions of treating physicians.
2. The Secretary of Labor had not prescribed any regulations adopting a treating physician rule as had the Social Security Commissioner; and
3. Important differences exist between the publicly funded Social Security disability program and benefit administration of private employer plans under ERISA.<sup>53</sup>

While the issue of accuracy in outcomes did find some reference in the opinion, the Court opined the matter was inappropriate for judicial resolution:

The question whether a treating physician rule would “increase the accuracy of disability determinations” under ERISA plans, as the Ninth Circuit believed it would. . . , moreover, seems to us one the Legislature or superintending administrative agency is best positioned to address.<sup>54</sup>

The Court did, however, take the occasion to comment upon the issue as a theoretical matter. While conceding the issue may be of an “empirical nature” that lay beyond the ken of the courts, the opinion nonetheless reflected skepticism that a rule of routine deference would contribute to accuracy in determinations.<sup>55</sup>

Thus, the *Nord* holding left treating physician opinions in no better posture than those of reviewing physicians, having no “special weight” and imposing no “discrete burden of explanation” when opposed.<sup>56</sup> In fact, treating physicians’ opinions may be subordinated to those of reviewing physicians inasmuch as the standard of review may only require that the plan administrator not arbitrarily refuse to credit a claimant’s reliable evidence.<sup>57</sup>

#### A. The Psychiatric/Physical Divide

Several courts have distinguished *Nord* in the context of a psychiatric evaluation on the view that an opinion based on personal examination is inherently more reliable. This conclusion rests on the premises that (1) psychiatric disease is revealed through subjective symptoms; and (2) personal observation

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53. *Id.* at 829-33

54. *Id.* at 832

55. *Nord*, 538 U.S. at 832.

56. *Id.* at 834

57. *Id.*

and interaction with the patient are required to evaluate these symptoms.<sup>58</sup> The reasoning in these cases draws on a substantial body of opinion favoring treating physicians' opinions where psychiatric symptoms are at issue.<sup>59</sup> The distinction has provided a means by which courts can reintroduce a rule of weight to the proceeding, thereby wresting away from the *Nord* decision some amount of deference to treating physicians.

One rationale upon which these courts base their decisions, making a distinction for treating physicians in psychiatric disability matters—as opposed to those involved in physical disability situations—is based on what the courts term subjective/objective symptoms. For example, one district court opined that “[i]n the context of a psychiatric disability determination, it is arbitrary and capricious to rely on the opinion of a non-treating, non-examining doctor because the inherent subjectivity of a psychiatric diagnosis requires the physician rendering the diagnosis to personally observe the claimant.”<sup>60</sup>

The distinction thus articulated does not comport with the prevailing views of physicians in medical practice.<sup>61</sup> There, clear-cut differentiations between subjective and objective symptoms finds little basis in diagnostic assessments. Instead, the psychiatric and physical aspects of pain are viewed more in the way of points on a continuum rather than sides of a dichotomy. There are subjective aspects to physical ailments, as well as physical manifestations of psychiatric ailments.

The idea that “therapeutic” dialogue comprises the standard treatment in psychiatric medicine, derived by means of a patient’s relation of his subjective feelings, is in fact something of a dated, romantic holdover from Freudian stereotypes in which analysts query patients on couches.<sup>62</sup> As the neuros-

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58. See, e.g., *Morse v. Corning Inc. Pension Plan for Hourly Employees*, No. 05-CV-6318, 2007 WL 610628, at \*9 (W.D.N.Y. Feb. 23, 2007); *Westphal v. Eastman Kodak Co.*, No. 05-CV-6120, 2006 WL 1720380, at \*5 (W.D.N.Y. June 21, 2006).

59. These opinions somewhat set themselves against the aforementioned trend away from the “deference to custom” rule, which until recently had been the standard in the medical malpractice field. See *supra* section I.B.

60. *Westphal*, 2006 WL 1720380, at \*4.

61. The distinction also raises the possibility of a false legal distinction. For example, tremors may be caused either by disease, such as Parkinson’s or Huntington’s, or by the manifestation of generalized anxiety or panic disorder. The Parkinson’s disease patient, suffering from a physical malady, will likely suffer from depression as well, and the typical symptom of the disease—tremors—which can be debilitating and incapacitating—is as likely to be associated with one cause as the other. That a psychiatrist treating physician’s diagnosis of debilitating tremors could receive deference under the law, as opposed to an internist treating physician making a similar diagnosis, is a matter of consequence that leaves the court system open to a potential abuse; such diagnoses, if properly couched in psychiatric terms, could receive preferential treatment in ERISA cases to those that have no psychiatric aspect.

62. Freud, a neurologist, attempted to approach neuroses in a psychological framework, and thereby greatly influenced the way that such maladies were treated and understood by the public. See Smith Ely Jeffrey, M.D., *Sigmund Freud and Psychiatry: A Partial Appraisal*, 45:3 AM. J. SOC. 326 (1939).

ciences have advanced, and with the advent of drugs such as Thorazine in 1954, as well as MAO inhibitors in the early 1950s, the treatment of mental health problems became increasingly driven by approaches unrelated to psychoanalysis.<sup>63</sup> Then, in 1980, a standardization of diagnostic protocols in the psychiatric fields appeared in the form of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.<sup>64</sup> The work, now in its fourth edition, refined both the criteria for diagnosing different mental disturbances and that for proscribing treatment. The manual provides a scientific, objective means by which to judge a psychiatric condition.<sup>65</sup> Thus, the idea that objective data is more within the purview of “physical” medicine than psychiatric, and that as a result, physical diagnoses, is not entirely the case. Today, psychiatric medicine relies on objective data as well as subjective, as does physical medicine.

In addition to the false dichotomy upon which such objective/subjective data distinctions rest is what modern studies have found with regard to the relationship between pain and mental stress, a mind-body continuum that a variety of clinical studies has established. A recent article on this matter states:

Depression and pain share biological pathways and neurotransmitters, which has implications for the treatment of both concurrently. A model that incorporated assessment and treatment for depression and pain simultaneously is necessary for improved outcomes...A growing body of literature has focused on the interaction between depression and pain symptoms. This interaction has been labeled by some authors as the depression-pain syndrome or depression-pain dyad, implying that the conditions often coexist, respond to similar treat-

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63. Interview by Roy F. Harmon, Jr., M.D. with Rodney Poling, M.D., in Columbia, Tennessee (Aug. 16, 2008) at Line 312 [hereinafter Poling Interview] (on file with author). “Thorazine” is the generic name for Chlorpromazine, a common sedative used in the treatment of schizophrenia, among other things. “MAO” Inhibitors stands for “Monoamine oxidase inhibitors,” a group of medications used to treat depression. PHYSICIAN’S DESK REFERENCE MEDICAL DICTIONARY, (Baltimore: Lippincott Williams & Wilkins, 2000).

64. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) [hereinafter DSM].

65. In fact, today, psychiatrists are as likely to conduct standard patient interviews, perform physical examinations, and proscribe medications to treat psychological ailments as they are to employ psychoanalysis in their work. Like any other physician, psychiatrists conduct clinical interviews, probing for the manifestation of patient’s problems in ways identical to the clinical interviews of general practitioners or pediatricians. Psychiatric symptoms may stem from physical bases—such as stroke, tumors, infectious diseases, stimulant addiction, etc.—and psychiatrists routinely order CT scans, MRIs, and other lab work to determine the causes—again, in ways no more subjective or objective in nature than those of “physical doctors.” In addition, psychiatrists review medical records on patients—the kind of objective data that some post-*Nord* courts set within the purview of non-psychiatric physicians. Psychiatrists review these records to determine if there is a history of a malady, and to discern the cause of the psychiatric distress. Poling Interview, *supra* note 50, at Line 171.

ments, exacerbate one another, and share biological pathways and neurotransmitters.<sup>66</sup>

Studies have shown that depressed patients had a greatly increased occurrence of physical pain, were more often fatigued, and wound up utilizing more health resources than those patients who did not suffer from depression.<sup>67</sup> Further, the presence of pain can mask the diagnosis of depression. The study found that

At least 75% of primary care patients with depression present with physical complaints exclusively and seldom attribute their pain symptoms to depression or other psychiatric illness. These physical complaints may be due to amplification of chronic physical disease and remain medically unexplained after extensive workup.<sup>68</sup>

The consequence of this misunderstanding leads to medical treatment for the pain exclusively, rather than an exploration of “the pain symptoms in a broader, biopsychosocial context.”<sup>69</sup>

Acknowledgement of this relationship between psychological and physical medical disorders is found in *Sheehan v. Metropolitan Life Insurance Co.*<sup>70</sup>

66. Matthew J. Bair, Rebecca L. Robinson, Wayne Katon & Kurt Kroenke, *Depression and Pain Comorbidity: A Literature Review*, 163 ARCHIVES OF INTERNAL MEDICINE 2433 (Nov. 10, 2003).

67. *Id.* at 2434. Other findings of the studies that support this mind-body pain continuum—one that casts doubt upon the rationale of a psychiatric-subjective/physical-objective dichotomy—include the following:

A large longitudinal cohort study has shown that depressive symptoms predict future episodes of low back pain, neck-shoulder pain, and musculoskeletal symptoms compared with those patients without depressive symptoms at baseline . . . Several studies have reported the association between depression and pain, specifically addressing how the risk of depression increases as a function of different aspects of worsening pain (e.g., severity, frequency, duration and number of symptoms). Patients with multiple pain symptoms (e.g., back pain, headache, abdominal pain, chest pain, and facial pain) are 3-5 times more likely to be depressed than patients without pain, and pain symptoms are associated with at least a two-fold increased risk for Co-existing depression. Additionally, a population-based study showed that subjects with chronic pain (define as pain for most days for at least a month) are 3 times as likely to meet depression criteria as those without chronic pain. The association between depression and pain becomes stronger as the severity of either condition increases. *Id.* at 235.

68. *Id.* at 241.

69. *Id.* Some physical conditions are so deeply related to psychiatric conditions that doctors in both fields are often called upon for treatment, such as fibromyalgia, panic attack, and anorexia nervosa. Interview by Roy F. Harmon, Jr., M.D. with Mark Seego, M.D., in Columbia, Tennessee (Sept. 17, 2008) Line 727 [hereinafter Seego Interview] (on file with author). In children, chronic abdominal pains and migraines are commonly associated with psychological stress. Interview by Roy F. Harmon, Jr., M.D. with Tony Smith, M.D. and Carol Broadway, M.D., in Columbia, Tennessee (Sept. 12, 2008) Line 727 [hereinafter Smith Interview] (on file with author). A call for an integration of legal and medical definitions of disability through a strong treating physician rule, one that acknowledges that “disability is context-driven,” is made in Schneider’s article, *supra* note 24.

70. 368 F. Supp. 2d 228 (S.D.N.Y. 2005).

There, the court cited “co-morbidity” as one of the reasons that the disability determination was so complex.<sup>71</sup> Comorbidity is the coexistence of two or more conditions that contribute to a patient’s life-threatening condition. In *Sheehan*, the patient, who had experienced a major heart attack, also suffered from “cardiac neurosis,” an intense fear of a cardiac recurrence that itself contributed to the patient’s poor health.<sup>72</sup> Such a condition would be classified under the DSM as “Anxiety Disorder Due to a General Medical Condition,” i.e., anxiety that arises from a stressor that is medical in nature, as opposed to some other normal stressor.<sup>73</sup> The *Sheehan* court recognized the duality of the patient’s illness when it spoke of two medical diagnoses failure to take into account both physical and psychiatric dimensions:

Sheehan’s comorbid illnesses of coronary artery disease and cardiac neurosis rendered him totally disabled....MetLife’s medical evidence fails to squarely address this issue. That failure stems from Dr. Stein’s narrow focus upon Sheehan’s cardiac condition to the exclusion of any psychiatric condition, and Dr. Givens’s narrow focus upon Sheehan’s psychiatric condition to the exclusion of any cardiac condition. Both Dr. Stein and Dr. Givens were expressing opinions about a patient who did not and does not exist. Sheehan did not suffer from a cardiac condition alone or from a psychiatric condition alone. He suffered, and suffers, from both. As the result of comorbidity, Sheehan is affected by “a confluence of factors contributing to sickness,” in Dr. Charno’s phrase; “a very vicious cycle,” in Dr. Parti’s phrase. That confluence, that cycle, disables Sheehan.<sup>74</sup>

The Court’s understanding of the condition’s complexity is in keeping with the mind-body pain continuum that medical practice recognizes.<sup>75</sup>

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71. *Id.* at 258.

72. *Id.*

73. DSM, *supra* note 64, at 436. Of course, clinical anxiety can also arise from normal, non-medical stressors—such as the loss of a family member. When the level of anxiety relative to the normal stressor is disproportionate, it is classified as Adjustment Disorder. Abnormal stressors, such as battlefield trauma or criminal violence, lead to “post-traumatic stress.” *See id.* at 623.

74. *Sheehan*, 368 F. Supp. 2d at 258.

75. Other co-dependent physical and psychological conditions are classified by the DSM as “anxiety due to a general medical condition.” DSM, *supra* note 64, at 623. In such a case, trying to distinguish between which evidence is subjective, related to the psychiatric component of the malady, as opposed to the purely physical illness, would be a futile process. In fact, a common index used by doctors of all disciplines is the Charlson Comorbidity Index, which predicts the one-year mortality rate for patients that have a range of comorbid conditions. “Dementia” is included among contributors to comorbid conditions. Mary E. Charlson, Peter Pompei, Kathy L. Ales & C. Ronald MacKenzie, *A New Method of Classifying Prognostic Comorbidity in Longitudinal Studies: Development and Validation*, 40 J. CHRONIC DIS. 373 (1987); *see also* Molly Sachdev, Jie Lena Sun, Anastasios A. Tsiatis, Charlotte L. Nelson, Daniel B. Mark & James G. Jollis, *The Prognostic Importance of Comorbidity for Mortality in Patients with Stable Coronary Artery Disease*, 43 J. OF THE AM. COLL. OF CARDIOLOGY 576 (2004). The very existence and use of such indices belies the easy distinctions made by the post-*Nord* psychiatric cases.



Another example of the sticky wicket of the pain/psychosis distinction is the recent decision of *Champion v. Black & Decker (U.S.) Inc.*<sup>76</sup> There, however, the court found the interplay between psychiatric and purely medical disorders to be defeating of the plaintiff's claims. Champion brought suit when Black and Decker terminated her disability benefits on the grounds that her illness stemmed from mental problems, only covered for thirty months under her ERISA plan. Champion suffered from seizures that were multi-determined:

Her actual epileptic seizures were mostly of the *petite mal* or "absence" variety and were thereafter controlled with medication. Treating physicians noticed that Champion also reported seizure-like events that were not epileptic seizures. These events were sometimes characterized as panic attacks and sometimes as "pseudoseizures." Pseudoseizures are a recognized medical diagnosis with symptoms closely resembling epilepsy, causing physicians often to misdiagnose one as the other. Champion was also diagnosed with various emotional and psychiatric conditions including anxiety, depression, panic attacks, and post-traumatic stress disorder.<sup>77</sup>

The lower court remanded the case, asking that the Plan determine the proper classification of Champion's disability and give her a chance to submit additional evidence. Champion's physician's opinions were to the effect that she was totally disabled by her epilepsy and pseudoseizures. However, the Plan concluded that the epilepsy was treatable with medication, and that the pseudoseizures were a mental health disorder. The termination was reaffirmed by the Plan, and the district court agreed that there was no abuse of discretion.

Upon reviewing the facts, the Fourth Circuit held that Champion's pseudoseizures fell within the defined range for mental health disabilities.<sup>78</sup> It also implied that had she been able to base her claim on the physical dimension of her seizures alone, her complaint on appeal might have met with different results:

Champion produced no evidence showing or tending to show that she could substantiate her disability claim on just her epilepsy. She produced persuasive evidence that she is disabled by her *pseudoseizures and epilepsy*. But because the Plan reasonably concluded that her pseudoseizures fell within the definition of mental health disability, her evidence does not support a claim that her epilepsy alone rendered her unable to work within the Plan's definition of disability.

In contrast, the Plan provided substantial reasons to believe that Champion would not be disabled without her mental health disabilities. Dr. Ebeling concluded from the record that Champion's physical

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76. 550 F.3d 353 (4th Cir. 2008).

77. *Id.* at 356–57.

78. *Id.* at 357. Champion offered evidence that her psychoseizures arose from physical causes, but the Court noted that the plan excluded mental disabilities whatever their causes--physical, medical, mental, or organic.

seizures were “relatively infrequent, not intractable, and would not preclude her from any occupation which does not require her to operate machinery or work at unprotected heights.” In accepting this conclusion, the Plan acted reasonably, especially when Champion’s own correspondence with the Plan supports the conclusion.<sup>79</sup>

Although the two cases ultimately turned upon different grounds, comparison of the two maladies themselves—cardiac neurosis on the one hand, pseudoseizures on the other—and the respective courts’ treatments of the interplay between these mental maladies with the purely physical diseases with which they co-occurred, is worthy of note. In one instance, the co-occurrence of the diseases is a factor in the court’s decision; in the other, the co-occurrence is what proves damning to the claim. The two cases highlight the shifting ground upon which courts stand when faced with disability claims of two natures: physical and psychiatric.

### B. ERISA Cases Favoring an Exception for Psychiatric Conditions

The opinion in *Sheehan v. Metropolitan Life Insurance Co.* has frequently been cited in support of favoring treating physicians’ opinions when mental symptoms are in issue.<sup>80</sup> *Sheehan* is a particularly interesting case in that it involved a disability claim based upon the aforementioned cardiac and psychiatric conditions combined. Again, this multi-caused medical condition is known in the medical vernacular as “comorbidity.”<sup>81</sup>

MetLife attempted to controvert Sheehan’s psychiatrist’s opinion on the strength of the opinion of a psychiatrist who had only reviewed Sheehan’s file. The court noted that “[w]hile the file contained a written report by . . . Sheehan’s treating psychiatrist, Dr. Givens [MetLife’s reviewing physician] did not examine or interview Sheehan himself.” The court faulted MetLife’s psychiatric evaluation of *Sheehan* on this point. It observed that:

Courts discount the opinions of psychiatrists who have never seen the patient for obvious reasons. Unlike cardiologists or orthopedists, who can formulate medical opinions based upon objective findings derived from objective clinical tests, the psychiatrist typically treats his patient’s subjective symptoms.<sup>82</sup>

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79. *Id.* at 361.

80. *Sheehan v. Metropolitan Life Ins. Co.*, 368 F. Supp. 2d 228 (S.D.N.Y. 2005).

81. *See infra* notes 99–101 and accompanying text.

82. *Sheehan*, 368 F. Supp. 2d at 255. Questions regarding the admissibility of subjective pain testimony in disability determinations also have a long history. *See generally* Margaret C. Rodgers, *Subjective Pain Testimony in Disability Determination Proceedings: Can Pain Alone be Disabling?*, 28 CAL. W. L. REV. 173 (1991). The Eighth Circuit set out what are known as the “Polaski factors” as means for evaluating subjective complaints of pain in a Social Security disability case. The factors include: 1) the amount of pain; 2) the daily activities of the claimant; 3) the effects of medication; 4) any precipitating and irritating factors; and 5) any functional restrictions. *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984). However, the same court refused to

The *Sheehan* court noted that the primacy of personal observation of such symptoms over remote evaluation finds support in other legal contexts. Collecting cases in a variety of different contexts, the court observed that “[c]ourts routinely discount or entirely disregard the opinions of psychiatrists who had not examined the individual in question at all or for only a limited time.”<sup>83</sup>

Importantly, the *Sheehan* court did not state its conclusions in categorical terms. In fact, the court took care to avoid such an interpretation of its holding, stating:

I do not undertake in this opinion to suggest a per se rule that a long term disability insurer can never conclude that a beneficiary is not psychiatrically disabled unless the insurer’s psychiatric expert has examined the beneficiary. There may be an unusual case where . . . a consulting psychiatrist can arrive at a sound opinion without ever examining, seeing or interviewing the individual in question.<sup>84</sup>

Nonetheless, on the facts presented, the court concluded that the testimony of a psychiatrist that never examined the plaintiff did not constitute substantial evidence supporting a denial of benefits.

Likewise, the Second Circuit, in *Winkler v. Metropolitan Life Ins. Co.*, an unpublished opinion, expressed reservations about benefit denials based upon the views of non-examining consultants.<sup>85</sup> The Court noted that MetLife based its decision “entirely on the opinions of three independent consultants who never personally examined [the plaintiff].”<sup>86</sup> The Court reconciled its holding with *Nord* by commenting that, “[w]hile administrators may credit

apply the factors in the ERISA context: “We see no reason to import wholesale, into what is essentially a private-law area, special rules developed for reviewing the decisions of administrative agencies.” *Conley v. Pitney Bowes*, 176 F.3d 1044, 1049–50 (8th Cir. 1999).

83. *Sheehan*, 368 F.Supp.2d at 254 (citing *People v. Espinoza*, 116 Cal.Rptr.2d 700, 718–19 (Ct. App. 2002) (“in a prosecution for molestation of a child, ‘L,’ where defendant ‘proposed to introduce testimony by a psychiatrist *who had never examined* L. that L. did not suffer from any mental illnesses diagnosed by any of the psychiatrists who actually examined her,’ appellate court affirmed trial court’s ruling that ‘the proffered evidence was speculative and therefore had little probative value’”); see also *Rollerson v. United States*, 343 F.2d 269, 270 (D.C. Cir. 1964) (“We think it necessary to point out that the value of a psychiatrist’s testimony depends largely upon his opportunities for observation and the facts he observes.”); *Jones v. United States*, 327 F.2d 867, 879–80 (D.C. Cir. 1963) (“Here the psychiatric evaluation apparently took but a few seconds and was limited to observing the patient during that time through prison bars”; report of psychiatric panel that defendant was mentally competent based upon so limited an observation “would not, in any event, be a predicate for any such adjudication”) (Wright, J., concurring); *Campbell v. United States*, 307 F.2d 597, 598 (D.C. Cir. 1962) (“Appellant says, and we agree, that the testimony of the psychiatrist relied upon by the Government was of little probative value. The psychiatrist had no information about the defendant’s mental condition, testified largely in terms of a legal conclusion, and had never seen defendant prior to the trial.”).

84. *Sheehan*, 368 F. Supp. 2d at 255 n. 18.

85. *Winkler v. Metro. Life Ins. Co.*, 170 F. App’x. 167, 2006 WL 509487 (C.A.2 (N.Y. 2006)).

86. *Id.* at \*2.

their own reliable evidence over the statements of treatment providers, . . . MetLife's exclusive reliance on second-hand opinions adds to the overall picture of its decision as less than fair."<sup>87</sup>

Though the Court went on to cite *Sheehan* for the proposition that "[f]irst-hand observation is especially important in the context of assessing psychiatric disabilities,"<sup>88</sup> the opinion stopped short of stating this principle in categorical terms. Noting other irregularities in *MetLife's* decisional approach,<sup>89</sup> the Court reserved the issue of "whether any factor, on its own, would warrant vacatur."<sup>90</sup>

Similarly, a Sixth Circuit unpublished opinion, *Smith v. Bayer Corp. Long Term Disability Plan*, emphasized the importance of personal observation in psychiatric cases, stating that:

[Though] the court in *Sheehan* engaged in *de novo* review, *Sheehan's* point is still relevant for our, albeit deferential, review of the medical evidence, because *Sheehan* highlights the inadequacy of record review when determining benefits for someone claiming a mental disability. An examination could have helped the plan administrator to better evaluate the severity of Smith's symptoms.<sup>91</sup>

The Court took care to distinguish *Nord*, observing that the opinions of treating physicians "should not necessarily be accepted over those of reviewing experts simply because the treating physicians physically examined the claimant."<sup>92</sup> The distinction drawn by the Court bears directly on the issue of whether the preference of treating physician opinions constitutes, in effect, an adoption of the treating physician rule. Reconciling its holding with *Nord*, the Court explained:

Though Bayer characterizes the district court decision as importing a treating-physician rule contrary to *Black & Decker Disability Plan v. Nord*, the district court did not do so. Rather, the district court deemed arbitrary and capricious the plan administrator's refusal to credit Smith's reliable evidence. That Bayer can point to opinions from its own experts does not insulate its decision from review, because we must "review the quality and quantity of the medical evidence and the opinions on both sides of the issues." Based on the facts of this case, rather than on a blanket rule of according outcome-determinative weight to treating or examining physicians, we deter-

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87. *Id.*

88. *Id.* (citing *Sheehan*, 368 F. Supp. 2d at 255).

89. For example, "MetLife's final denial relied (as had its consultants) on the absence of any objective cognitive testing, notwithstanding that MetLife never raised this issue with Winkler during the various stages of his application . . .," and suggestions that MetLife "cherry-pick[ed]" the evidence. *Winkler*, 170 F. App'x at \*2.

90. *Id.* at \*1.

91. *Smith v. Bayer Corp. Long Term Disability Plan*, 275 F. App'x 495, 508 (6th Cir. 2008).

92. *Id.* at 507-08.

mine that Bayer arbitrarily and capriciously rejected Smith's evidence and breached its fiduciary duty to make certain that reliance on its experts' advice was reasonably justified under the circumstances.<sup>93</sup>

Thus, the Court distances its approach from one employing a rule of weight by casting the analysis in terms of a case-by-case review of the quality and quantity of medical evidence.

The district court's opinion in *Westphal v. Eastman Kodak Co.* appears to take the weight analysis a step further. In that case, the court held that an ERISA plan administrator abused its discretion when it disregarded the opinions of the claimant's two treating physicians in favor of contrary opinions by two reviewing physicians.<sup>94</sup>

Noting the deferential standard of review required under the terms of the ERISA plan, the Court observed that the plan administrator's decision must be upheld unless the decision was "without reason, unsupported by substantial evidence or erroneous as a matter of law."<sup>95</sup> In view of the claimant's symptoms, however, the court concluded that the plan administrator's decision could not be sustained even under this liberal standard.

The plaintiff applied for early retirement based upon disability after twenty years' employment with Kodak.<sup>96</sup> In support of the disability claim, the plaintiff cited various conditions including loss of sleep, memory loss, manic depression, CPD [chronic pulmonary disease], and angina.<sup>97</sup> Two treating physicians' opinions supported this claim, one from his treating physician and the other from his treating psychiatrist.<sup>98</sup> In addition, the claim was supported by an independent psychiatric evaluation obtained during application for Social Security benefits.<sup>99</sup>

Nonetheless, the plan administrator rejected the claim based upon the opinions of two reviewing physicians. The district court took particular note of the fact that the opinions were of doctors who had not treated or examined the claimant. The court concluded that in cases of psychiatric disability claims, the "inherent subjectivity of a psychiatric diagnosis requires the physician rendering the diagnosis to personally observe the claimant."<sup>100</sup> Distinguishing *Nord*, the court stated that:

While it is true that a Plan Administrator is not required to give a preference to a treating physician's opinion, the Administrator must support his findings with substantial evidence. In this case, the substantial evidence does not support a finding that the plaintiff is not

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93. *Id.* at 508 (citations omitted).

94. *Westphal v. Eastman Kodak Co.*, No. 05-CV-6120, 2006 WL 1720380, at \*1 (W.D.N.Y. June 21, 2006).

95. *Id.* at \*2.

96. *Id.* at \*1.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Westphal*, 2006 WL 1720380, at \*4.

disabled because the evidence reveals that every doctor who treated or examined the patient found him to be disabled. The only evidence that suggests that plaintiff is disabled is insubstantial in that it consists of two reports prepared by doctors who did not have the benefit of observing the plaintiff in person. As stated above, the opportunity to interview and interact with a psychiatric patient is crucial to the diagnosis of a psychiatric disability. Therefore, this case is distinguishable from a case involving a physical injury, where a diagnosis may be more properly based on the review of objective medical evidence by a non-examining doctor.<sup>101</sup>

Given the “inherent subjectivity of a psychiatric diagnosis,” the court opined that “it is arbitrary and capricious to rely on the opinion of a non-treating, non-examining doctor...”<sup>102</sup>

Likewise, the district court in *Morse v. Corning Inc. Pension Plan for Hourly Employees* reached a similar conclusion, relying extensively on the *Westphal* decision.<sup>103</sup> As in *Westphal*, the claimant offered opinions of her treating physician and therapist in support of her disability claim.<sup>104</sup> The plan administrator denied the claim for benefits based upon the opinions of reviewing physicians who had not treated or examined the plaintiff.<sup>105</sup>

After exhaustion of administrative remedies, suit was filed in federal district court. Quoting *Westphal*, the court stated:

Therefore, in the context of a psychiatric evaluation, an opinion based on personal examination is inherently more reliable than an opinion based on a cold record because observation of the patient is critical to understanding the subjective nature of the patient’s disease and in making a reasoned diagnosis. Subtleties in the patient’s mannerisms, the nuances that are derived from her speech and gestures cannot be observed and evaluated by the non-examining physician. This is all necessary in the evaluation process and cannot be done in absentia nor by merely evaluating the treating physicians’ notes and opinions.<sup>106</sup>

The *Morse* court’s view of what is entailed in a psychiatric diagnosis is most representative of the subjective/objective distinction question above.<sup>107</sup>

### C. Cases Opposing an Exception for Psychiatric Conditions

In opposition to the foregoing cases, several decisions have rejected the view that psychiatric symptoms require elevated consideration of treating phy-

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101. *Id.* at \*6.

102. *Id.* at \*4.

103. *Morse*, No. 05-CV-6318, 2007 WL 610628, at \*9.

104. *Id.* at \*8.

105. *Id.* at \*3.

106. *Id.* (citing *Westphal*, 2006 WL 1720380 at \*5).

107. See *supra* section III.A.

sician opinions. In *Kushner v. Lehigh Cement Co.*, for example, the district court distinguished *Sheehan* based upon its facts.<sup>108</sup> *Sheehan*, observed the court, involved application of a *de novo* standard of review.<sup>109</sup> From this perspective, the *Sheehan* holding is limited to the relatively uncommon scenario in which the plan administrator has not reserved to itself discretion in reviewing benefit denials.

The court explained that the *de novo* standard of review permitted consideration of treating physician opinions beyond that available when review is limited to considerations of abuse of discretion by the administrator, stating:

Plaintiff misapplies *Sheehan v. Metropolitan Life Ins. Co.*, 368 F.Supp.2d 228 (S.D.N.Y. 2005) in which the district court found the administrator assessed only a claimant's cardiac condition, not his co-morbid psychiatric complaints. The court considered additional evidence regarding the reliability of the treating physician's testimony only for use with a *de novo* review. . . . Unlike *Sheehan*, an abuse of discretion standard applies, and LINA also appropriately evaluated both of plaintiff's purported conditions.<sup>110</sup>

Moreover, the court in *Kushner* further limited *Sheehan* to its facts based upon the *Sheehan* court's concession that the opinions of reviewing physicians that had not examined the claimant may prevail over treating physician opinions in some cases. The court noted that *Sheehan* "acknowledged that face-to-face contact between an insurer's psychiatric expert and the claimant is not always necessary."<sup>111</sup> Actually, the *Sheehan* opinion categorized that scenario as "unusual," but the court did conduct *de novo* review, and the opinion does reject a "per se" rule favoring examining physician opinions.<sup>112</sup>

Though the *Kushner* court distinguished *Sheehan* based largely upon the standard of review applied, *Kushner* rejects a key premise assumed in *Sheehan*. As the Sixth Circuit stated in *Smith v. Bayer Corp. Long Term Disability Plan*, *supra*, regardless of the standard of review, "*Sheehan's* point is still relevant for [an], albeit deferential, review of the medical evidence, because *Sheehan* highlights the inadequacy of record review when determining benefits for someone claiming a mental disability."<sup>113</sup> *Kushner* explicitly rejects this proposition, citing "the wide acceptance in ERISA and disability cases of record reviews by psychiatrists and other doctors, without in person examinations, to uphold the propriety of claims decisions based on such reviews."<sup>114</sup>

108. *Kushner v. Lehigh Cement Co.*, 572 F. Supp. 2d 1182, 1192 n. 9 (C.D. Cal. 2008).

109. *Id.*

110. *Id.*

111. *Id.*

112. *Sheehan*, 368 F. Supp. 2d at 255 n. 18.

113. *Smith*, 275 F. App'x 495 at 508.

114. *Kushner*, 572 F. Supp. 2d at 1192.; *see also* *Semien v. Life Ins. Co. of N. Am.*, 436 F.3d 805, 812 (7th Cir. 2006) (denial upheld where independent psychiatric consultant reviewed claimant's medical history without personal examination); *Vercher v. Alexander & Alexander Inc.*, 379 F.3d 222, 230 (5th Cir. 2004) (record review by psychiatric consultant supported ad-

On the other hand, the district court in *Gannon v. Aetna Life Insurance Co.*, rejected the “categorical rules” stated in cases such as *Westphal* as inconsistent with the rejection of the “treating physician rule” in *Nord*.<sup>115</sup> Quoting the *Nord* opinion, the court noted a preference for “preserv[ing] the greatest flexibility for...operating claims processing systems consistent with the prudent administration of a plan.”<sup>116</sup>

The district court also rejected the reasoning in the *Sheehan* line of cases in *Island View Residential Treatment Ctr. Inc. v. Bluecross Blueshield of Mass., Inc.*,<sup>117</sup> on similar grounds. Cases suggesting that “an exception exists for determining whether a claimant is disabled in psychiatric cases” create an unjustified exception to *Nord* in the view of the court.<sup>118</sup>

The *Island View* court also distinguished *Sheehan*, noting that:

In all the cases cited where a court found a psychiatric exception, the issue was whether a claimant was disabled. The insurance providers denied disability benefits because non-treating doctors determined the claimants were not disabled. The non-treating physicians’ diagnoses were in direct conflict with the plaintiffs’ treating physicians’ conclusions regarding the claimant’s disabilities.<sup>119</sup>

By contrast, the court observed, the case at bar did not involve a disputed diagnosis but rather “a determination of whether certain types of treatment were reimbursable given [the claimant’s] condition and her health insurance plan.”<sup>120</sup> In other words, *Sheehan* addressed a difference in medical opinion on the question of impairment as opposed to whether the claimant was “eligible to receive reimbursement for treatment based on her symptoms and insurance.”<sup>121</sup>

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ministrator’s appropriate determination that plaintiff should not receive disability benefits); *Parker v. Kemper Ins. Co.*, 2006 U.S. Dist. LEXIS 48885, at \*25-28 (N.D. Cal. 2006) (no independent medical examination required where two physicians and a psychologist analyzed the medical record); *Fox v. Kaiser Found. Employee Benefit Plan*, 2006 U.S. Dist. LEXIS 40975, at \*48-49 (N.D. Cal. 2006) (denial of benefits relying on psychiatric consultant record review was reasonable); *Toth v. Auto. Club of Cal. Long Term Disability Plan*, No. CV014653MMMRCX, 2005 WL 1877150, at \*32 (C.D. Cal. Jan. 27, 2005) (no obligation to conduct psychiatric IME); *Lawless v. Northwestern Mut. Life Ins. Co.*, 360 F. Supp. 2d 1046, 1056 (N.D. Cal. 2005) (no abuse of discretion where insurer obtained two psychiatric consulting record reviews); *Voight v. Metropolitan Life Ins. Co.*, 28 F. Supp. 2d 569, 580 (C.D. Cal. 1998) (upholding insurer’s denial in part based on psychiatric record reviews).

115. *Gannon v. Aetna Life Ins. Co.*, No. 05 Civ. 2160(JGK), 2007 WL 2844869, at \*13 n. 6 (S.D.N.Y. Sept. 28, 2007).

116. *Id.*

117. *Island View Residential Treatment Ctr., Inc. v. Bluecross Blueshield of Mass., Inc.*, Civil Action No. 07-10581-DPW, 2007 WL 4589335, at \*24 (D. Mass. Dec. 28, 2007).

118. *Id.*

119. *Id.* at \*25.

120. *Id.*

121. *Id.*



#### IV. DIFFICULTIES IN DERIVATION OF PRINCIPLES OF REVIEW

The problem thus stated by the foregoing authorities is whether a consistent principle may be found that (1) can justify the preference given treating physician opinions in the series of district court opinions discussed above; and (2) is consistent with circumscribed role of such opinions allowed for in *Nord*. A range of factors peculiar to the factual and legal aspects of benefit claims complicates this task.

Aside from the specific question of the relative value to be assigned medical opinions, reconciling decisions in which courts exercise judicial review of ERISA benefit denials already poses significant challenges. The reasons are several. First, disability claims exhibit a considerable variance in the basis for the benefit claim, ranging from differences in symptoms, supporting and opposing evidence, and disabilities claimed. Second, the procedural history of a claim can make an enormous difference in outcome.

Perhaps most significant, however, is the variance in the standard of judicial review. In most disability cases, the plan documents will confer discretion on the plan administrator. Under the seminal Supreme Court decision, *Firestone Tire & Rubber Co. v. Bruch*, if a plan administrator possesses discretionary authority, the district court reviews benefit denials under the deferential "arbitrary and capricious" standard.<sup>122</sup> As has been aptly noted, "it is incredibly difficult for an insured to defeat summary judgment in an ERISA case under the arbitrary and capricious standard."<sup>123</sup>

Adding to the complexity in some cases, such as *Sheehan*, for example, the plan documents will not grant the necessary discretion (typically by oversight). In such cases, judicial review will be more searching, since the standard is *de novo*. Moreover, even in cases where the abuse of discretion standard applies, the reviewing court may take into account the plan administrator's conflict of interest where the same entity both funds claims payment and adjudicates benefit disputes.<sup>124</sup> Thus, the variance in the standard applied by the reviewing court complicates the derivation of general principles from the case law.

Therefore, extrapolating general principles from judicial opinions requires great attention to context. Yet, some useful generalizations may nonetheless be discovered in the cases. The following section will attempt to identify some of these principles before evaluating the post-*Nord* cases addressing psychiatric or mental symptoms.

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122. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989).

123. *Fischer v. Liberty Life Assurance Co.*, No. 05 C 3256, 2008 WL 4874302, at \*6 (N.D. Ill. June 16, 2008).

124. *Id.*

### A. The Rule of Reason: *Nord v. Black & Decker*

*Nord* rejected the importation, as it were, of the treating physician rule as it is understood in the context of Social Security disability cases. The *Nord* opinion did not give plan administrators absolute discretion, however, as it made clear from its concluding remarks. Though rejection of the treating physician rule, as understood in Social Security cases, means that courts will not “automatically...accord special weight to the opinions of a claimant’s physician,” neither may plan administrators “arbitrarily refuse to credit a claimant’s reliable evidence, including the opinions of a treating physician.”<sup>125</sup>

*Nord* framed the treating physician rule as one imposing a categorical (“automatic”) requirement that treating physician’s opinions be given credit for a privileged (though defeasible) status of correctness – in other words, “special weight.” In rejecting this rule, the Court stated its position in terms of reasonableness.

A plan administrator abuses its discretion when it arbitrarily – that is, without a principled, rational basis – denies a claim for benefits. Refusing to credit the opinion of a treating physician is objectively unreasonable and, as such, arbitrary. On the other hand, if a court finds that the plan administrator has considered the treating physician’s opinion, but sided with the reviewing physician, the question of whether the treating physician’s opinion was given proper credit becomes more complicated.

### B. Review of “Quality and Quantity” of Evidence Required

The *Nord* requirement of reasonableness has been expanded upon in opinions that explain what review is required under an abuse of discretion standard. Stated negatively, the highly deferential standard of review does not require uncritical adherence to the plan administrator’s decision.<sup>126</sup> Otherwise, judicial review would comprise no more than a “rubber stamp” of the decision by the plan. As the Seventh Circuit has said, “‘Deferential review is not no review,’ and ‘deference need not be abject.’”<sup>127</sup>

The proper lens through which to analyze physicians’ opinions, whether treating or not, thus becomes the *Nord* metrics of the “quality and quantity” of the evidence. From this perspective, the plan administrator need not give “special weight” to the assessments of treating physicians, but neither may it “arbitrarily refuse to credit [[the] claimant’s reliable evidence, including the opinions of . . . treating physician[s].”<sup>128</sup> While there is “‘nothing inherently objectionable about a file review by a qualified physician in the context of a benefits determination,” the very fact of “file review” remains “a factor to be

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125. *Nord*, 538 U.S. at 834.

126. *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161 (6th Cir. 2003).

127. *Hess v. Hartford Life & Accident Ins. Co.*, 274 F.3d 456, 461 (7th Cir. 2001).

128. *Michaels v. Equitable Life Assur. Soc’y of the United States*, No. 07-4256, 2009 WL 19344, at \*9 (3d Cir. Jan. 5, 2009).

considered in reviewing the propriety of an administrator's decision regarding benefits."<sup>129</sup> In view of the Supreme Court's application of a multi-factor analysis in judicial review of benefit denials by conflicted fiduciaries (*infra*, page 35), the isolation of file review as a factor for evaluation is quite significant.

The Sixth Circuit has refined the analysis of file review as a factor properly considered in judicial review in a series of opinions. The foundation for this analysis lies in the premise that the reviewing court is not foreclosed from reviewing the "quality and quantity of medical evidence."<sup>130</sup> As the Sixth Circuit stated:

This obligation inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan was able to find a single piece of evidence—no matter how obscure or untrustworthy—to support a denial of a claim for ERISA benefits.<sup>131</sup>

Thus, the reviewing court should evaluate the treating physician's opinion in view not only of the cumulative effect of the conclusions, but also from the standpoint of the quality of the diagnostic conclusions. When plan administrators make "important credibility determinations regarding a claimant's medical history based solely on a file review," the Sixth Circuit has suggested that a file review of the patient's medical history may be inadequate.<sup>132</sup>

The effect of this consideration favors the treating physician's opinion in a number of factual settings. For example, in *Turner v. Retirement & Benefit Plans Committee Robert Bosch Corp.*,<sup>133</sup> the court favored the treating physicians' opinions as forensically superior to those of the reviewing physicians. The court stated:

In the interests of clarity, the court emphasizes that it does not find these physicians more persuasive simply because they are Plaintiff's treating physicians. Instead, it finds their opinions more persuasive for the simple fact that they have more information upon which to

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129. *Kufner v. Jefferson Pilot Fin. Ins. Co.*, 595 F.Supp.2d 785, 795 (W.D. Mich. 2009) (citing *Evans v. UnumProvident Corp.*, 434 F.3d 866 (6th Cir. 2006)).

130. *McDonald*, 347 F.3d at 172.

131. *Id.*

132. *Epling v. Am. United Life Ins. Co.*, Civil Action No. 08-02-ART, 2009 WL 129785, at \*8 (E.D. Ky. Jan. 20, 2009) (citing *Calvert v. Firststar Fin., Inc.*, 409 F.3d 286, 297 n.6 (6th Cir. 2005)); *see also* *Creel v. Wachovia Corp.*, No. 08-10961, 2009 WL 179584, at \*8 n.22 (11th Cir. Fla. Jan. 27, 2009) ("[T]he decision not to accord special weight to the views of the claimant's physician must be based on 'reliable evidence,' which would involve something more than a paper-based peer review for disabilities involving subjective proof.").

133. 585 F. Supp. 2d 692 (D.S.C. Oct. 31, 2007).

base such opinions than physicians who only have the benefit of a written record.<sup>134</sup>

Viewed in context, a focus on the quality and quantity of evidence will not always present advantages to the treating physician's opinions. First, in some instances the patient's medical conditions will be adequately presented in the medical records. Secondly, the review of the treating physician's opinion may be countered by evidence derived from an independent medical examination. In other words, the apparent preference given *treating physicians'* opinions in post-*Nord* cases is better comprehended as a preference for the insights of an *examining physician* in some contexts. This advantage does not belong exclusively to the treating physician.

Moreover, where the dispute centers not on the patient's diagnosis, but on the *effect* of that diagnosis under the benefit plan or insurance policy, the significance of the examining physician's perspective will be diminished.<sup>135</sup> In such cases, the province of the physician is circumscribed since the determination turns not on evidence, but on legal interpretation. Finally, the credentials or experience of the treating physician on the medical question under review may lead to doubts as to his or her conclusions notwithstanding any advantages otherwise inherent in the opportunity for direct observation of the patient.<sup>136</sup>

### C. The Effect of Conflicts of Interest: *MetLife v. Glenn*

Since the *Nord* decision, the Supreme Court has revisited the issue of conflicts of interests in judicial review of benefit denials. In *Metropolitan Life Insurance Co. v. Glenn*, the Court confirmed that the payment of benefits by the same entity that adjudicated claims constituted a conflict of interest.<sup>137</sup> In such cases, the Court stated that the reviewing court must take into account "several different, often case-specific, factors, reaching a result by weighing all together."<sup>138</sup> Where a conflict of interest is found to exist, any one factor will

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134. *Id.* at 707 n.9.

135. *Doe v. Hartford Life & Accident Ins. Co.*, Civil Action No. 05-2512, 2008 WL 5400984, at \*1 (D.N.J. Dec. 23, 2008) (the significance of a treating physician versus non-treating physician is minimized as Doe's condition is not in dispute; what is in dispute is how bipolar disorder is meant to be treated under the Policy language); *Fitzpatrick v. Bayer Corp.*, 2008 U.S. Dist. LEXIS 3532, at \*2 (S.D.N.Y. Jan. 17, 2008) ("the operative question in this case is not whether Plaintiff actually suffered from CFS and/or fibromyalgia, but instead whether the Plaintiff's CFS and/or fibromyalgia rendered her 'totally disabled' within the definition of the Plan and thus unable to work").

136. *Cf. Dennison v. Metro. Life Ins. Co.*, Civil Action No. 3:07-CV-317-DCK, 2009 WL 77216, at \*7 (W.D.N.C. Jan. 8, 2009) ("The Defendants point out that the Plaintiff's holistic doctor has no training or expertise in occupational training and provided no objective medical data to support her conclusions.").

137. 128 S. Ct. 2343 (2008).

138. *Id.* at 2345.

act as a tiebreaker in close cases: “the degree of closeness necessary depending upon the tiebreaking factor’s inherent or case-specific importance.”<sup>139</sup>

*Glenn*’s effect on disability determinations will be interesting to observe. In most cases, the disability carrier will be deemed conflicted, since it will both pay claims and adjudicate benefit claims. To what extent, then, will the disregard of treating physicians’ opinions constitute a significant factor in judicial review? While that issue remains open—and most likely, a matter for case by case consideration—the rule of reason enunciated in *Nord* should require more of the plan administrator in terms of a principled, rational decision than if a conflict were not found to exist.

The emergence of the pragmatic factor-based approach in evaluating the effect a conflict should have in judicial review of benefit denials has an ironic twist. As discussed, *supra*, the neglect of the treating physician’s opinions in *Regula v. Delta Family-Care Disability Survivorship Plan*, played an important role in the Ninth Circuit conclusion that the plan fiduciary’s benefit decisions were tainted by a conflict of interest.<sup>140</sup>

While the Supreme Court rejected the Ninth Circuit’s countermeasure of applying a treating physician rule in such cases, *Nord* did not foreclose scrutiny of the benefit decision along the lines of whether the treating physician’s opinions had been given due regard along with other reliable evidence. At this juncture, the concerns that animated the Ninth Circuit in *Regula* intersect with the factor-based review called for by the Supreme Court in *Glenn*.

After the *Glenn* decision, the district courts may take all factors bearing on the decision of conflicted fiduciaries into account (though they must retain the abuse of discretion standard of review if called for by the plan document). If file review of a patient’s medical history may be isolated as a factor, as the Sixth Circuit has suggested it may, then principles of judicial review of conflicted fiduciary’s decisions come near to embracing one of the premises of the *Regula* opinion.

The *Regula* Court observed that “in light of the Plan’s apparent conflict of interest, the administrator’s decision to reject the opinions of the appellant’s treating physicians constitutes material, probative evidence of a conflict.”<sup>141</sup> What *Nord*, and more recently, *Glenn*, demonstrate, however, is that the evaluation of physician opinions, as well as the presence and effect of conflicts of interest, must be evaluated without resort to “special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict.”<sup>142</sup>

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139. *Id.* at 2351.

140. *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1147 (9th Cir. 2001), *vacated by* *Delta Family-Care Disability & Survivorship Plan v. Regula*, 539 U.S. 901 (2003).

141. *Id.*

142. *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2345 (2008).

V. ASSAYING PHYSICIAN OPINIONS' WEIGHT AFTER *NORD*

In view of the foregoing principles, the line of cases favoring treating physician opinions in the setting of psychiatric or mental illness symptoms appears reconcilable with *Nord*, for the most part. The rationale for these decisions has most frequently been rooted in the superior information available to the treating physician for evaluating the patient's condition.

When courts evaluate a benefit denial based upon information available to the physician rendering an opinion, the courts do no more than follow *Nord*'s rule of reason. Plan administrators must not unreasonably refuse to credit the reliable evidence offered by a claim, including the opinions of treating physicians, in reaching a decision on a benefits claim.

In *Sheehan*, *Winkler*, and *Smith*, *supra*, the courts avoided an "automatic" credit of any "special weight" to the treating physician's opinions. On the other hand, the courts did view the treating physicians as having a better posture for evaluating the disability of the claimant. These decisions are supported by a review of the quality and quantity of the medical evidence and the opinions on both sides of the issues.

To the extent that courts have emphasized the importance of subjective versus objective symptoms, however, the analysis has strayed into unnecessary ambiguity. The *Sheehan* court heeded the boundary necessary after *Nord* by avoiding adoption of a *per se* rule.

The *Westphal* court's opinion, on the other hand, appears to extend considerably further. By concluding that "in the context of a psychiatric evaluation, an opinion based on personal examination is inherently more reliable than an opinion based on a cold record because observation of the patient" due to the "subjective" nature of the patient's disease, the court goes too far. A rule of weight is no more than a classification of evidence without based upon predetermined experience with outcomes.

While the *Westphal*'s opinion may be justified on the facts, the conclusion that a class of opinions may be "inherently" superior based upon the subjective nature of the complaints constitutes a categorical approach to medical evidence antithetical to the *Nord* holding. As suggested in *Island View*, *supra*, such "categorical rules" are inconsistent with the rejection of rules of weight in *Nord*.<sup>143</sup>

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143. Of interest in the Social Security Administration's own acknowledgement of the objective and subjective sides of medicine: "[Treating sources] are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from objective medical findings alone . . ." 20 C.F.R. § 404.1527(d)(2), 416.927(d)(2) (2006). Rachel Schneider's article also points to the Social Security Administration's policy statement, which acknowledges that: "[O]pinions always have a subjective component, because the effects of medical conditions on individuals vary so widely, and because no two cases are ever exactly alike, it is not possible to create rules that prescribe the weight to be given to each piece of evidence that [may be taken] into consideration in every case." Schneider, *supra* note 25, at 402

What is largely unaddressed thus far, however, is the effect of the decision in *MetLife v. Glenn* on the issue of the weight accorded treating physician's opinions. Most disability benefits are provided through insurance companies. These companies will also adjudicate claims in the vast majority of cases. Thus, a conflict of interest exists; post-*Glenn*, that is an important factor to be taken into account.

*Nord* stands for the proposition that plan administrators must not unreasonably refuse to credit the treating physicians' opinions. Pre-*Glenn* authority holds that courts must evaluate not only the quantity but the quality of medical evidence. After *Glenn*, it seems entirely reasonable to assume that courts may take a more searching evaluation of benefit denials when a conflicted plan administrator (as will often be the case), prefers the opinions of reviewing physicians over treating physicians.

## VI. CONCLUSION

In short, it seems that the courts have de facto turned the treating physician rule into an "examining physician" factor—one used to determine if there has been a first-hand evaluation of the state that has allegedly led to the impairment. However, the distinction on the grounds of objective/subjective medicine in the two medical disciplines is unnecessary and untenable.

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(quoting Standards for Consultative Examinations and Existing Medical Evidence, 56 Fed. Reg. 35934-35 (1991) (codified at 20 C.F.R. pts. 404, 416)). Schneider goes on to say "[t]he Social Security regulations thereby reveal a basic tension in that they strive for objective identification of disability while acknowledging that the decision-making procedure includes a certain amount of subjectivity and individualization." Schneider, *supra* note 25, at 402. If this is true of the medical decision-making process, it is not contingent upon whether such decisions are being made in the Social Security rather than the ERISA context, and distinctions about objective/subjective diagnoses are not reasons for excepting psychiatric problems from *Nord's* decision.